Quality Leadership

July 2006 – May 2007
Personal Outcome Measures®
Performance Indicators Report for:

STATE OF SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES DIVISION OF DEVELOPMENTAL DISABILITIES

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Partners in Excellence; Leadership for the Journey.

Table of Contents

INTRODUCTION

Between July 1, 2006 and May 31, 2007, seven provider organizations contracting with the South Dakota Department of Human Services, Division of Developmental Disabilities participated in accreditation reviews using The Council on Quality and Leadership's (CQL) *Personal Outcomes Measures® 2000 Edition*. One provider organization transitioned to CQL's *Quality Measures 2005®*. CQL's accreditation review process relies heavily on *Personal Outcome Measures®* interviews with people who receive services. Both of these instruments assesses the quality of life experienced by the people who are interviewed and, combined with assessments of either Organizational Assurances and Organizing Principles or Shared Values and Basic Assurances®, determine the quality of services delivered by organizations. A secondary purpose of the accreditation review is to determine the overall effectiveness of supports provided through Developmental Disabilities Services resulting in meaningful outcomes for the citizens of South Dakota.

Overall, findings indicate that the providers in the state of South Dakota remain among the strongest in the nation. Four of the eight providers received a 3-year term of accreditation and one entered into a 4-year accreditation partnership agreement with CQL based on *Quality Measures 2005®*.

Accreditation reviews were conducted at the following provider organizations during the 2006-2007 South Dakota fiscal year. **(Table 1**)

Table 1 Participant Organizations and Accreditation Results

Organization, City	2006-2007 Review Dates	Accreditation Results
ACHIEVE Sioux Falls	August 22-25, 2006	Accredited
VOA – West Oak Sioux Falls	October 10-13, 2006	Accredited
Black Hills Workshop and Training Center *(*using *Quality Measures 2005®)* Rapid City	December 4-8, 2006	Accredited
Ability Building Services Yankton	January 23-26, 2007	Accredited
Black Hills Special Services Cooperative Sturgis	February 27 – March 2, 2007	Accredited
ATC, Inc. Aberdeen	March 26-30, 2007	Accredited
ADVANCE Brookings	April 16-19, 2007	Accredited
Northern Hills Training Center Spearfish	May 15-19, 2007	Accredited

To assure consistency, CQL assigned specific Quality Enhancement Specialists to be the lead for each review. This is the fourth year of data collection and analysis for organizations in South Dakota.

ABOUT THIS REPORT

This year's annual report to the State of South Dakota Department of Human Services, Division of Developmental Disabilities presented some particular challenges. During this fiscal year cycle, once again eight provider organizations were accredited by CQL. One of these eight however, Black Hills Workshop and Training Center, transitioned to *Quality Measures 2005*®. The remaining seven providers chose to continue using the *Personal Outcome Measures® 2000 Edition* accreditation process. This mix of applications, though small, presented the question of whether to add a separate section addressing the one organization that transitioned to the new measures or to begin the process of transition in this report.

The decision was to utilize a combination of these two options. Therefore, when analyzing data regarding Personal Outcomes, the data have been reconfigured to align with the *Quality Measures 2005*® 21 outcomes and when analyzing data regarding Assurances and Principles the measures for *Personal Outcome Measures® 2000 Edition* are used. This combination seemed to make sense as review and analysis of the four outcomes that were eliminated with the *Quality Measures 2005*® (*People have time, space, and opportunity for privacy; People choose their daily routine; People are satisfied with services;* and *People are satisfied with their personal life situation*) proved to be in alignment with CQL's factor analysis which led to the elimination of these four outcomes with the publication of *Quality Measures 2005*®. South Dakota data from the (7) seven providers using *Personal Outcome Measures® 2000 Edition* for their accreditation reviews had very high average outcomes and supports present in these four areas in the aggregate sample of 58 people from this fiscal year cycle.

A new addition to this year's report, CQL's *Social Capital Index®,* can be found beginning on page 37. The *Social Capital Index®* is an interesting piece of data and is broken out into several subsets (by age, under 50 years old and over 50 years old, and by congregate, as opposed to more independent living situations). Juxtaposed against the *Personal Outcome Measures®* as the central focus, with *Basic Assurances®* for Health, Safety, and Human Security on one side and *Community Life®* on the other, the *Social Capital Index®* gives an interesting snapshot of how well integrated, included and contributing people are at present. Over time, these data and analyses will prove to be an interesting journey.

This report includes the following information:

- Interview sample selection of people receiving services
- Quantitative and qualitative reviews of the *Personal Outcome Measures®* interviews
- Results summary for the Organizational Assurances
- HCBS Requirements – Notes on Waiver Application, Appendix H
- Overviews of most promising practices as assessed through the Organizing Principles
- Comparisons of the *Personal Outcome Measures®* assessments with national averages compiled by CQL from over 6,400 interviews completed between 1993 and 2007 **(Table 4)**
- CQL's *Social Capital Index®* with the aggregate data from all eight (8) provider organizations **(Tables 9-11)**

METHODOLOGY

Sample Selection Specific to the Data Collection Process

The CQL Lead Quality Enhancement Specialist chose a representative sample of the people supported in each organization as interview participants. In selecting each sample group, there was an attempt to represent the characteristics of the overall population supported by an organization. Therefore, the sample was selected from a list of people who made up a balance of characteristics related to gender, age, disability, communication abilities, type of services received, and geographic location. Fifty-eight (58) people receiving services participated directly in the review processes. Those interviewed ranged in age from 11 to 77 years.

The *Personal Outcome Measures*® assessment process involved face-to-face interviews with people receiving services through the Division of Developmental Disabilities. Additionally, follow-up interviews were conducted with managers and coordinators to validate and add to information learned during the initial interviews. A select number of personal records was also reviewed. Once the information gathering process was complete, the compiled information was used to determine the presence of outcomes and supports in people's lives.

Interview Process Utilizing the *Personal Outcome Measures*®

The *Personal Outcome Measures*®*,* as individually defined by the users of services, have been shown to be strong measures of quality. The measures provide information that helps to identify which services are working well regardless of how resources have been allocated. The *Personal Outcome Measures*® are unique in the measurement of quality in services for people, as the focus of measurement is on the results of services rather than the process for delivering services. The *Personal Outcome Measures*® assess the impact of services on the quality of life for the people receiving those services. The number of outcomes present in people's lives determines the quality of life for the person. The number and types of supports present determine the degree to which the person's quality of life is supported by the organization.

Demographics Identified for Analysis

Age range is the first category in the analysis. Of the 58 people in the interview sample, no families of children under the age of six were interviewed. One family and young person between the ages of 7-16 were interviewed. Eleven young adults between the ages of 17-22 years, 30 people between the ages of 23-49 years, and 16 people aged 50 years and over were interviewed. **(Table 2)**

Table 2 Age Ranges of Individual Participants

Age Range	Number in Sample	% of Total Sample
0-6 years	0	0
7-16 years	1	2%
17-22 years	11	19%
23-49 years	30	52%
50+ years	16	28%

Type of living arrangement is the second category to be analyzed. Of the 58 people interviewed, nine people lived with family, in their own homes, or in foster homes; 20 people lived in group settings with 24-hour support; and 29 people lived in settings identified as supported apartments, monitored apartments, or other supported living settings. Since there was only one person interviewed who owned a home, one person who lived independently in an apartment, and seven who lived with family or in Foster Care, these groups have been included in the "other living" category found in all graphs that follow pertaining to demographics for living arrangements. **(Table 3)**

Table 3 Type of Living Arrangement

Type of Living Arrangement	Number in Sample	% of Total Sample
Group setting with 24-hour support	20	35%
Other Living, including Supported Apartments or other Supported Living, including living with family or owning a home (only 9 of 38 lived with family or owned a home).	38	65%

HCBS REQUIREMENTS

In reviewing the Waiver Application for Home and Community Based Services (HCBS), specifically Appendix "H" which clearly outlines expectations for the waiver's Quality Management Strategy (QMS), there are clearly many strong correlations to be made between these expectations and CQL's *Quality Measures 2005®* and CQL's contractual partnership with the South Dakota Department of Human Services, Division of Developmental Disabilities. These correlations also exist between CQL's *Personal Outcomes Measures® 2000 Edition*. It is evident that an even stronger correlation emerges between the waiver expectations and processes and protocols with CQL's *Quality Measures 2005®* accreditation.

The addition of several new protocols more closely align with waiver requirements as outlined in Appendix "H" of the waiver application. Appendix "H" states:

> *The "Quality Management Strategy, QMS, focuses on discovery activities or processes to assess, review, evaluate or otherwise analyze a program, process, operation or outcome. The results of such discovery activities should provide a clear picture of the state's progress in meeting an assurance. Relevant discovery activities may include interviews with participants and providers, observation of program operations, financial reviews, record/chart reviews, analysis of operations data such as incidents and complaints, claims data, fair hearings and appeals data or the results of licensure/certification reviews. Discovery activities also might include conducting a structured review targeted to a geographic area or type of service, special studies, or securing the services of an outside entity to perform an oversight/evaluation function".*

The "cross-walk" between CQL's *Quality Measures 2005®* and the CMS Quality Framework is attached at the end of this report as Attachment A.

CQL's accreditation process has always focused on very specific accountabilities for health, safety and human security and, with the publication of our *Quality Measures 2005®*, these expectations take on an even deeper meaning with higher expectations and accountabilities. Additional protocols applied during accreditation reviews utilizing CQL's *Quality Measures 2005®* include people directly supported by the organization, family members, legally authorized representatives, organizational staff, and identified leaders as well as community members affiliated in some way with the organization. Attention to areas for Health, Safety and Human Security with CQL's *Basic Assurances®* measures and the focus on *Shared Values* of the organization both internally and externally within its community of operation, provide higher accountabilities and deeper meaning. Individual meetings with people supported in Personal Outcome interviews, along with additional protocols utilizing focus groups from this wider array of stakeholders both within and without the organization, provide us with even more meaningful data and higher expectations.

As more South Dakota providers transition to the *Quality Measures 2005®* these protocols and processes will prove to be even more meaningful and valuable as they relate to the waiver application Appendix "H". Future reports will provide analysis of data collected through these protocols and processes.

Home and Community Based Services (HCBS) waiver requirements are, in part, measured by various elements of the CQL Accreditation review process. A number of the *Personal Outcome Measures®* speak to compliance with HCBS requirements, including: *People choose personal goals; People*

perform different social roles; People are connected to natural support networks; People exercise rights; People are free from abuse and neglect; and *People experience continuity and security*. Certain Organizing Principles also give some indication of the involvement that users of services have in the service delivery system. The following briefly summarizes some of the information found in subsequent tables for Organizational Assurances of Health, Safety and Welfare; Organizing Principles; and National Comparative Data.

PEOPLE ARE CONNECTED TO NATURAL SUPPORT NETWORKS

	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n=58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	66%	46%	55%	63%
Support Present	87%	76%	76%	77%

National data for this outcome show that 63% of those interviewed have this outcome and 77% are supported in achieving this outcome. The South Dakota averages for the review year 2006-2007 indicate that 55% of those interviewed during accreditation reviews had the outcome and 76% had the support necessary to achieve the outcome.

PEOPLE CHOOSE PERSONAL GOALS

	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n=58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	77%	63%	76%	47%
Support Present	68%	67%	77%	48%

For the 2006-2007 review year, 76% of the people interviewed have this outcome in their lives. Seventy-seven percent of the people are supported to set goals and decide their own dreams and desires. This is a very high increase over the previous year. This indicates that a very high percentage of those interviewed are asked what they want to achieve. The data also indicate that more people are supported to plan for and accomplish their chosen goals.

PEOPLE PERFORM DIFFERENT SOCIAL ROLES

	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n=58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	26%	57%	43%	31%
Support Present	34%	54%	46%	32%

For the 2006-2007 review year, 43% of those interviewed have this personal outcome and 46% are supported to attain or keep the outcome present. This is a decrease from 2005-2006 and an increase from the 2004-2005 review year. Again, South Dakota data are somewhat above national averages for this outcome and support (31% and 32% present, respectively).

PEOPLE EXERCISE RIGHTS

Contract Year	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n-58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	74%	70%	81%	46%
Support Present	77%	67%	69%	42%

Data for 2006-2007 reflect outcome and support percentages much higher than those of other accredited organizations in the United States. The national averages show 46% of people interviewed have this outcome and 42% have the necessary support to attain the outcome.

PEOPLE ARE FREE FROM ABUSE AND NEGLECT

Contract Year	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n=58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	66%	87%	76%	86%
Support Present	85%	89%	98%	90%

After an increase from the 2004-2005 to 2005-2006 year, the 2006-2007 figures have decreased for the outcome, but continue to increase for the support. This would indicate that the provider organizations are doing an excellent job identifying instances of abuse, neglect, mistreatment or exploitation, but there may be people who still suffer some mental anguish from past negative experiences in this regard. The outcome average of 76% is below the national average, but the support for this outcome is above the national benchmark and only two percentage points below 100%.

PEOPLE EXPERIENCE CONTINUITY AND SECURITY

	2004-2005 South Dakota (n=46)	2005-2006 South Dakota (n=47)	2006-2007 South Dakota (n=58)	1993-2006 CQL National Data (n=6,424)
Outcome Present	87%	74%	71%	81%
Support Present	89%	76%	69%	78%

The data for 2006-2007 show a decrease in the outcomes and organizational supports from 2005-2006 and a decrease in the percentage of people reporting the outcome present even from 2004-2005.

PERSONAL OUTCOME MEASURES®

The *Personal Outcome Measures*® are a powerful tool for evaluating personal quality of life and the degree to which organizations individualize supports to facilitate outcomes. People define outcomes for themselves. The outcomes are non-prescriptive; they have no norms. Each person is a sample of one. Each person defines friendship, health or respect uniquely. Thus, the meaning and definition of personal outcome items will vary from person to person. As a result, an organization can only design and provide the needed supports after it figures out how the person defines his or her outcomes.

Personal outcomes are important because they put listening to and learning from the person at the center of organizational life. *Personal Outcome Measures*® enable us to learn about people in new and different ways. They provide a guide to person-directed planning. The *Personal Outcome Measures*® provide an information pathway to knowledge about the person and enable organizations to identify people's priorities. Knowing about people's priority outcomes directs planning efforts.

Factor One – My Self: Who I am as a result of my unique heredity, life experiences and decisions.

People are connected to natural supports.
People have intimate relationships.
People are safe.
People have the best possible health.
People exercise rights.
People are treated fairly.
People are free from abuse and neglect.
People experience continuity and security.
People decide when to share personal information.

Outcomes and supports in this factor are those that are most directly related to assurances for Health, Safety and Human Security. There appears to be a downward trend with many of the outcomes and supports within this factor. The outcomes of *People have intimate relationships; People have best possible health; People are treated fairly; People are free of abuse, neglect, exploitation and mistreatment;* and *People experience continuity and security* all have lower percentages present than from the 2005-2006 interview cycle.

Additionally, in all but one outcome area (*People are free of abuse, neglect, exploitation, and mistreatment*) those living in congregate settings have lower outcomes present than those who live in more natural settings. Supports for the outcomes of *People are safety; People have best possible health, People exercise rights; People are treated fairly;* and *People experience continuity and security* also show lower percentages present than in the 2005-2006 interview cycle. As with the outcomes, supports in all but one outcome area (*People are safe*) are lower for those people living in congregate settings than for those living in more natural settings. See Graphs 1.1, 1.2, 2.1, and 2.2 below for supporting data.

STRENGTHS AND COMMENDATIONS

- Most people interviewed had best possible health given each unique situation. Screenings for various exams were identified and occurring for individualized health needs in most cases.
- All provider organizations have a zero tolerance policy for abuse, neglect, mistreatment, and exploitation.
- People supported are well informed about their record of personal information and have access to these records. The provider organizations have done an outstanding job of teaching people about their personal information and who can and cannot have access to this information.

RECOMMENDATIONS AND OPPORTUNITIES

- Organizational efforts need to continue regarding supports for people in having the type and frequency desired in relation to connections to natural support networks.
- Ensure that organizational systems contribute to the maintenance of and continuation of best possible health. This includes assisting people to stay informed about and how to access preventative screenings and evaluations that are consistent with their age and risk factors.
- Ensure that due process is afforded everyone, even in instances where limitations have occurred as a result of a health or safety issue.
- Many of the provider organizations need to ensure that protocols for annual review of continued need for Legally Authorized Representatives includes discussion regarding alternatives to "guardianship" (such as, durable power of attorney, surrogate decision maker, limited representation) and that this is assessed as appropriate to each person and information regarding alternatives is provided to people and their current legally authorized representative.

Factor Two – My World: Where I work, live, socialize, belong or connect.

People choose where and with whom they live.
People choose where they work.
People use their environments.
People live in integrated environments.
People interact with other members of the community.
People perform different social roles.
People choose services.

Another downward trend from 2005-2006 is evident with the outcomes and supports within this factor. Four of seven data points for outcomes – *People choose where they work; People use their environments; People interact with other members of the community;* and *People perform different social roles* – are lower than the previous cycle of interviews. Five of seven data points for supports in this factor show decreases – *People choose where they work; People use their environments; People live in integrated environments; People interact with other members of the community;* and *People perform different social role*s all show lower percentages than data collected during the last cycle of interviews.

As might be anticipated, outcome data for choosing where to live is lowest, well below 50 percent, for those people reported to be living in group situations and is highest for those living in other types of living situations, such as supported apartments, with family, or in their own homes. Support for people living in other living situations outside of a congregate setting is very high; while support for people who remain living in congregate settings is quite low. Once again, all outcomes and supports in this factor, as in Factor One, are lower for those people who live in congregate settings.

Supporting data for these outcome and supports can be found in Graphs 3.1, 3.2, 4.1, and 4.2 below.

STRENGTHS AND COMMENDATIONS

- Many people were members and had involvement with People First, which resulted in deepening understanding about rights and the exercise of these rights, choice and personal freedoms.

RECOMMENDATIONS AND OPPORTUNITIES

- Organizational efforts to continue exploring people's interests may lead to more meaningful and valued social roles. Many people have interests that, with continued exploration, could develop into meaningful social roles. Organizations are encouraged to support these interests, realizing that some people's hobbies may evolve into social roles over time.
- Provider organizations are encouraged to continue providing experiences and education about work and social options that are available so people can more truly define what integration means to them in their lives.
- Provider organizations are encouraged to continue with a focus on supporting people to develop and take part in meaningful social roles with the frequency they desire.

Factor Three – My Dreams: How I want my life (self and world) to be.

People choose personal goals.
People realize goals.
People participate in the life of the community.
People have friends.
People are respected.

Interestingly, this factor shows the greatest area of strength of all three factors. Both outcome and support averages remain at or well above national averages. The outcome and support for *People are respected*, however, appear to be in a downward trend, falling 8% and 5% respectively from the last interview cycle, although still remaining above the national averages. Once again, all outcome and support averages are lower for those people who live in congregate settings as opposed to those who do not. See Graphs 5.1, 5.2, 6.1, and 6.2 below for supporting data.

STRENGTHS AND COMMENDATIONS

- The personal goals identified by people were the focus of the services being provided.
- People continue to be supported in choosing personal goals.
- People continue to build friendships.

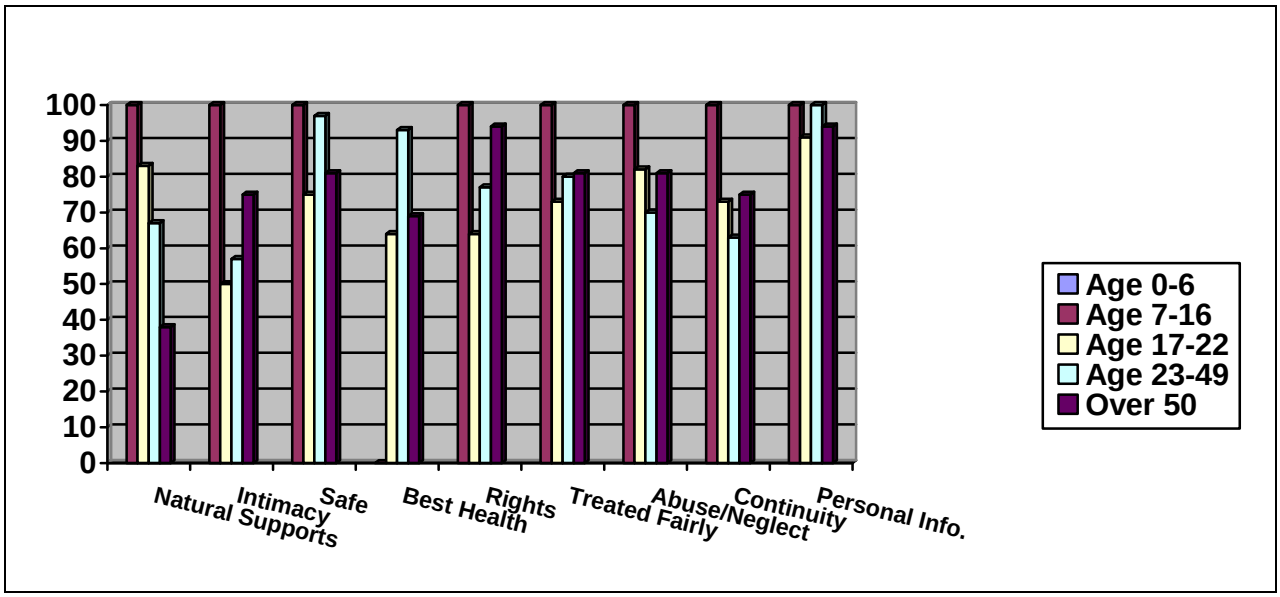
RECOMMENDATIONS AND OPPORTUNITIES

- Provider organizations need to increase the focus on supporting people to participate in community life with the frequency they desire.
- Provider organizations are encouraged to explore and analyze the outcome and support components of respect to discover the reasons this outcome area is on the decline.

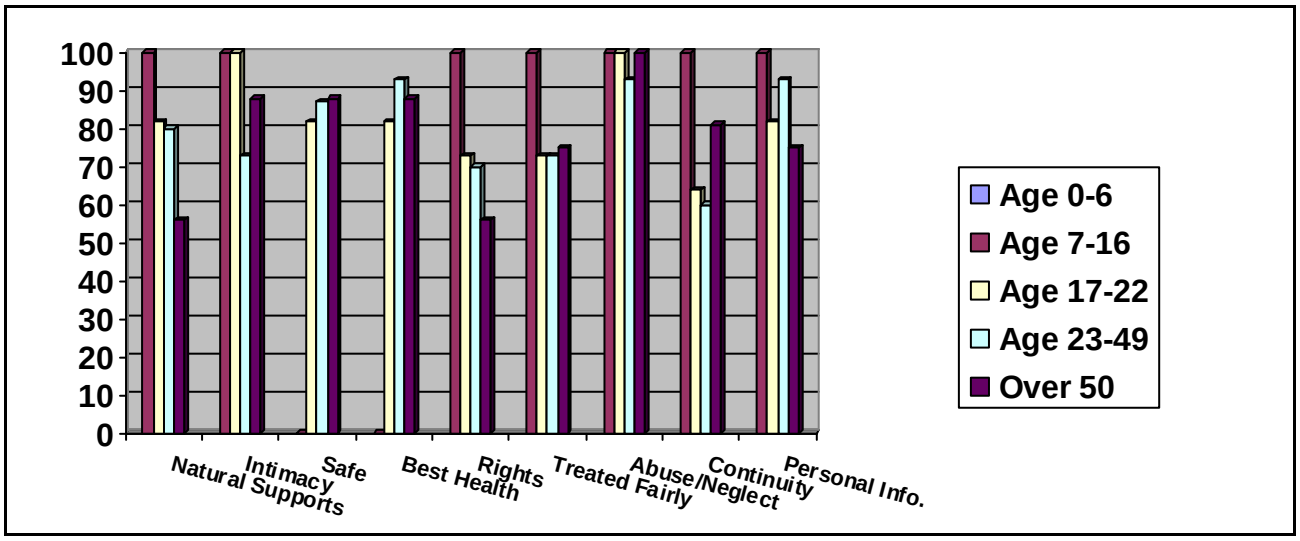
Table 4 Comparative Data – Percent Present

		1993-2006 CQL National Data (n=6,424)		South Dakota 2005-2006 (n=47)		South Dakota 2006-2007 (n=58)		South Dakota Differences 2006-07 vs 2005-06	
		Outcome	Support	Outcome	Support	Outcome	Support	Outcome	Support
My Self	People remain connected to natural support networks.	63	77	46	76	55	76	**+9**	**0**
	People have intimate relationships.	72	68	78	76	74	81	**-4**	**+5**
	People are safe.	87	82	89	89	89	83	**0**	**-6**
	People have best possible health.	75	74	87	87	86	89	**-1**	**-2**
	People exercise rights.	46	42	70	74	81	69	**+11**	**-5**
	People are treated fairly.	53	52	83	78	81	76	**-2**	**-2**
	People are free from abuse and neglect.	86	90	87	89	76	98	**-11**	**+9**
	People experience continuity and security.	81	78	74	76	71	69	**-3**	**-7**
	People decide when to share personal information.	78	69	80	74	98	86	**+18**	**+12**
My World	People choose where and with whom to live.	45	55	50	67	57	72	**+7**	**+5**
	People choose where they work.	39	50	59	72	55	69	**-4**	**-3**
	People use their environments.	77	80	91	96	86	88	**-5**	**-8**
	People live in integrated environments.	35	42	41	57	46	48	**+5**	**-9**
	People interact with other members of the community.	72	75	87	94	84	89	**-3**	**-5**
	People perform different social roles.	31	32	54	54	43	46	**-11**	**-8**
	People choose services.	47	49	63	70	76	81	**+13**	**+11**
My Dreams	People choose personal goals.	47	48	63	67	76	77	**+13**	**+11**
	People realize personal goals.	83	82	87	89	89	89	**+2**	**0**
	People participate in the life of the community.	72	81	67	94	72	86	**+5**	**-8**
	People have friends.	57	60	52	61	65	71	**+13**	**+10**
	People are respected.	78	82	96	98	88	93	**-8**	**-5**

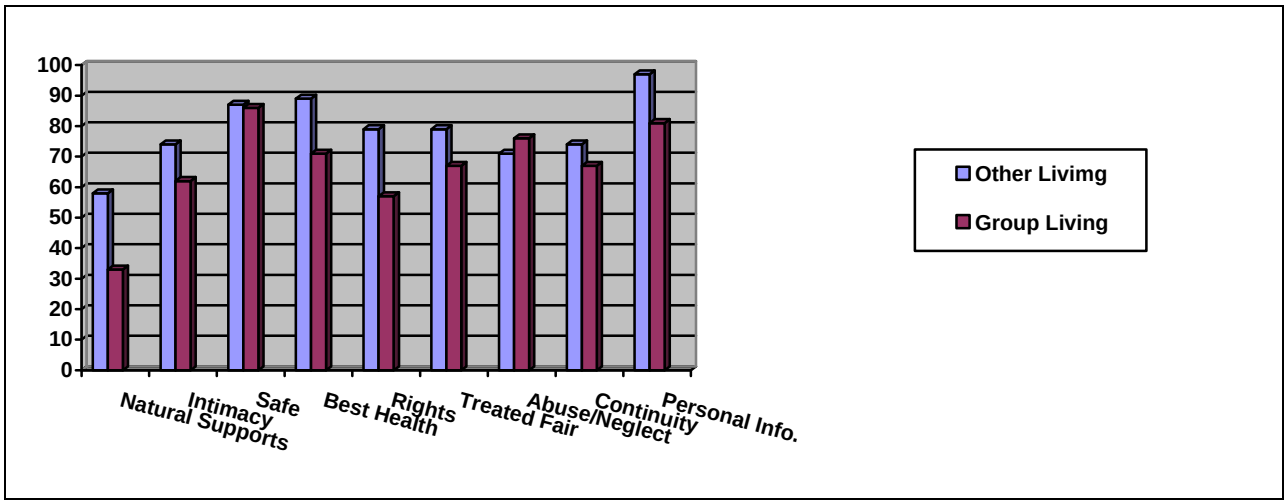
Graph 1.1 **Percentage of Outcomes achieved by various age groups – Factor One – My Self**



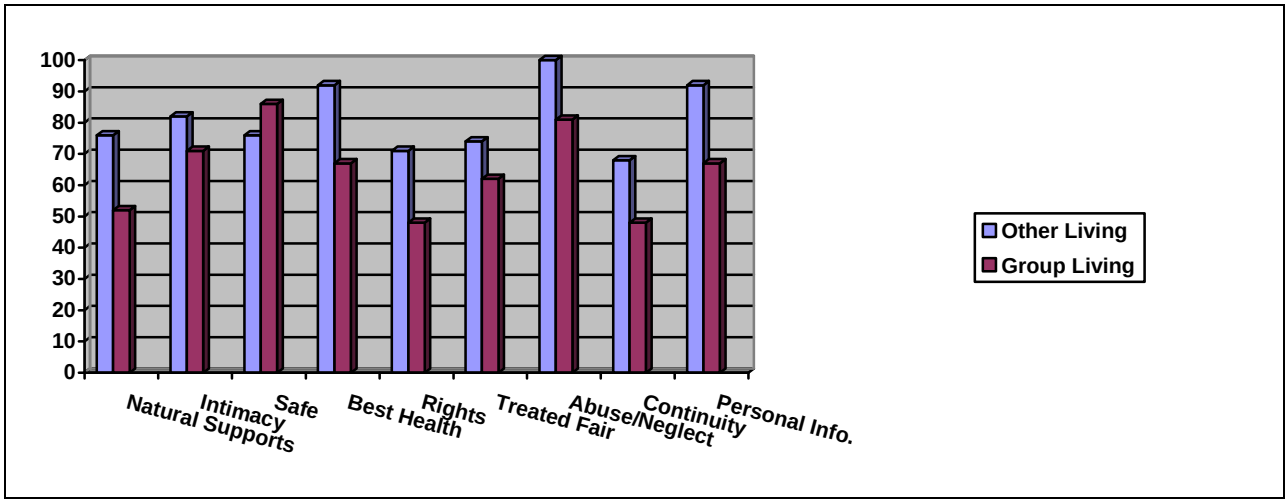
Graph 1.2 Percentage of Supports achieved by various age groups – Factor One – My Self



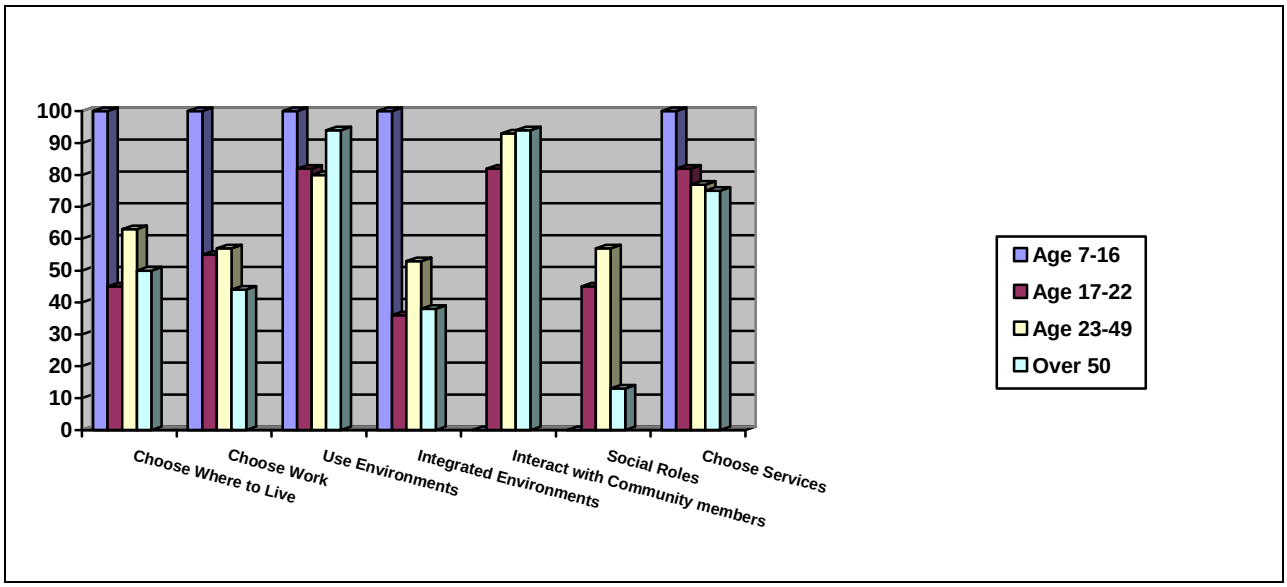
Graph 2.1 Percentage of Outcomes achieved by living arrangement – Factor One – My Self



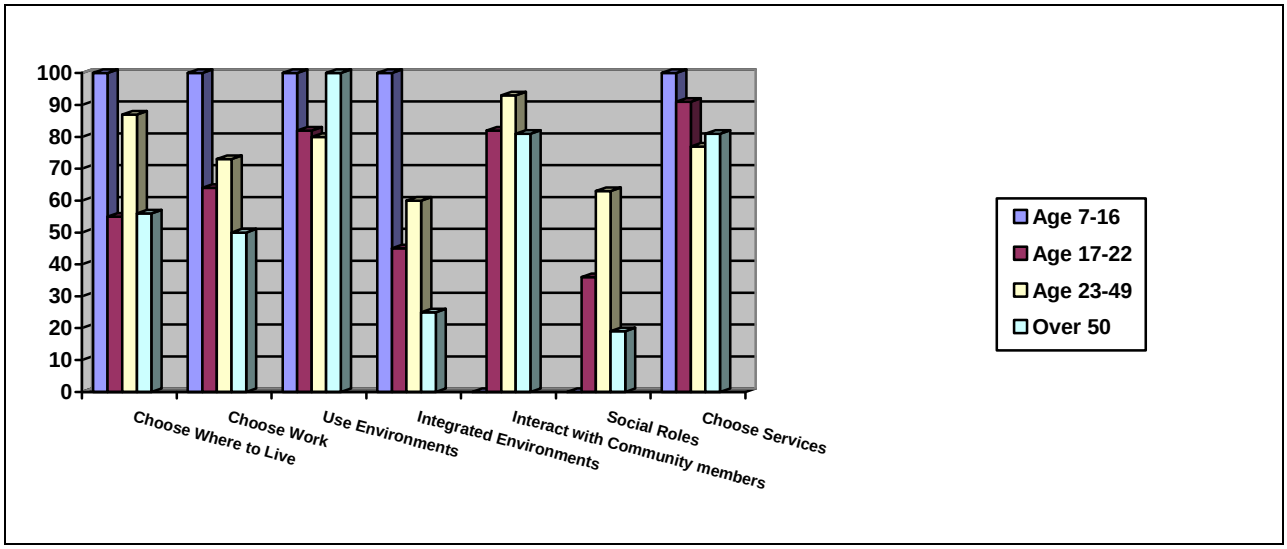
Graph 2.2 Percentage of Supports achieved by living arrangement – Factor Two – My Self



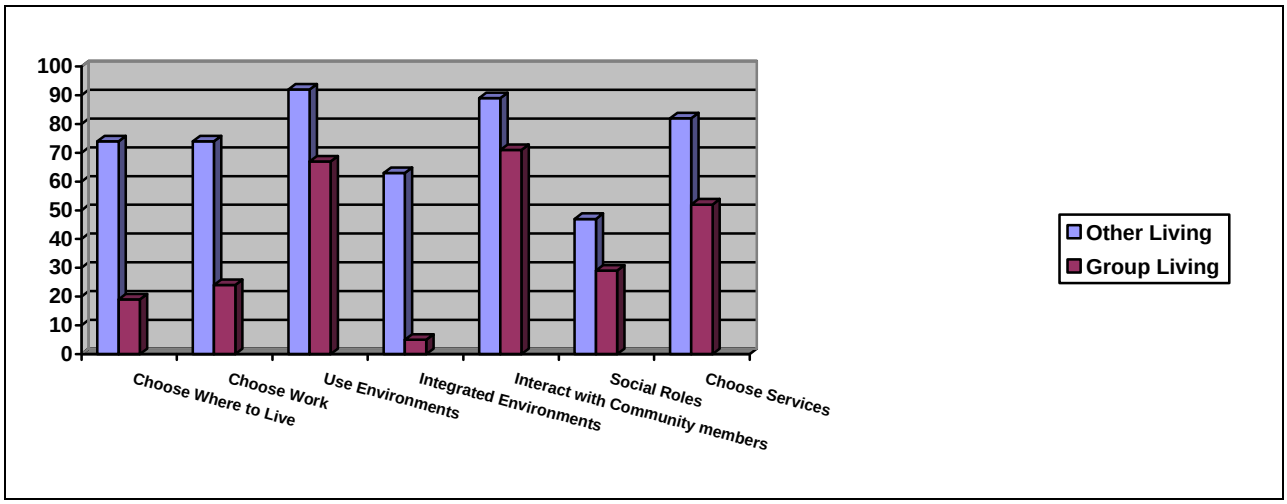
Graph 3.1 **Percentage of Outcomes achieved by various age groups – Factor Two – My World**



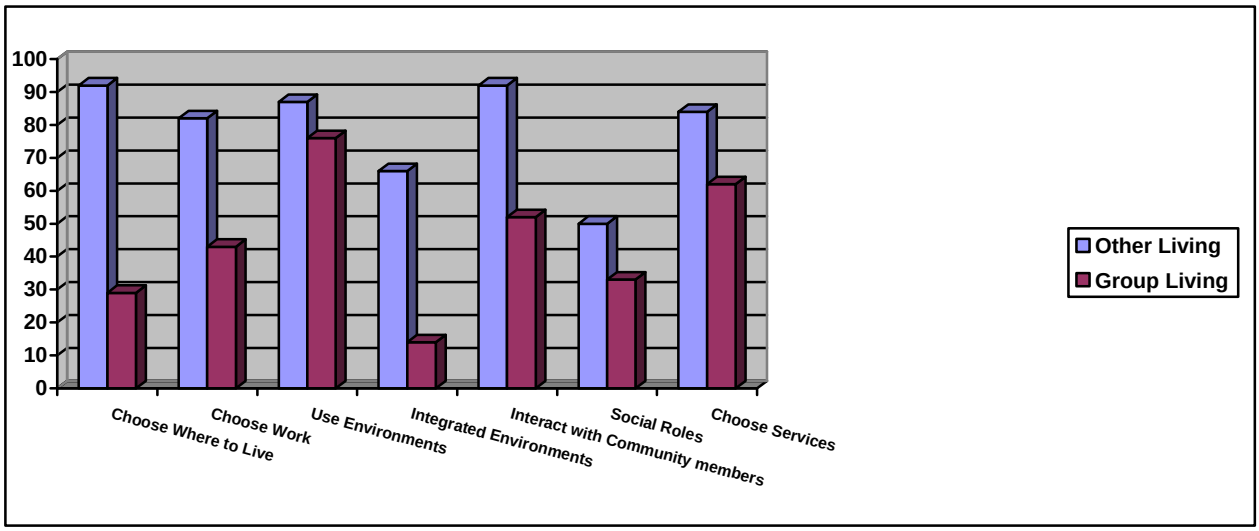
Graph 3.2 **Percentage of Supports achieved by various age groups – Factor Two – My World**



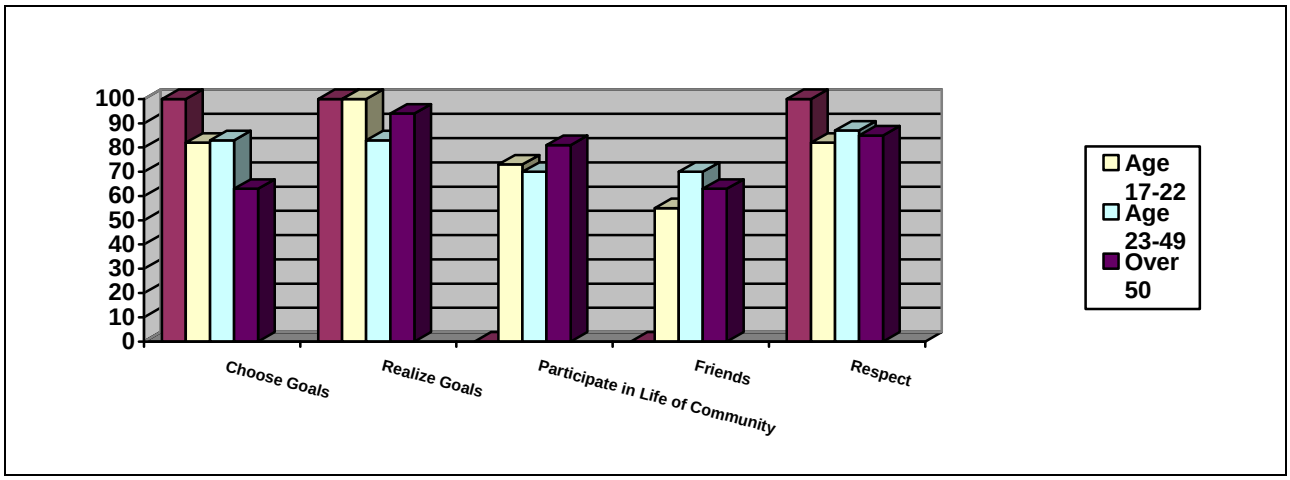
Graph 4.1 Percentage of Outcomes achieved by living arrangement – Factor Two – My World



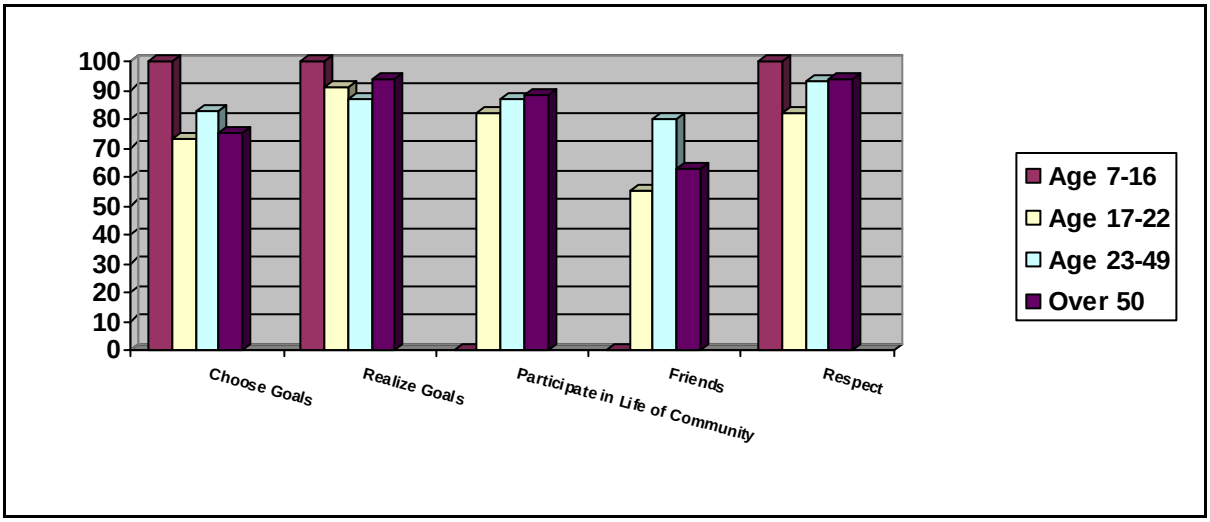
Graph 4.2 Percentage of Supports achieved by living arrangement – Factor Two – My World



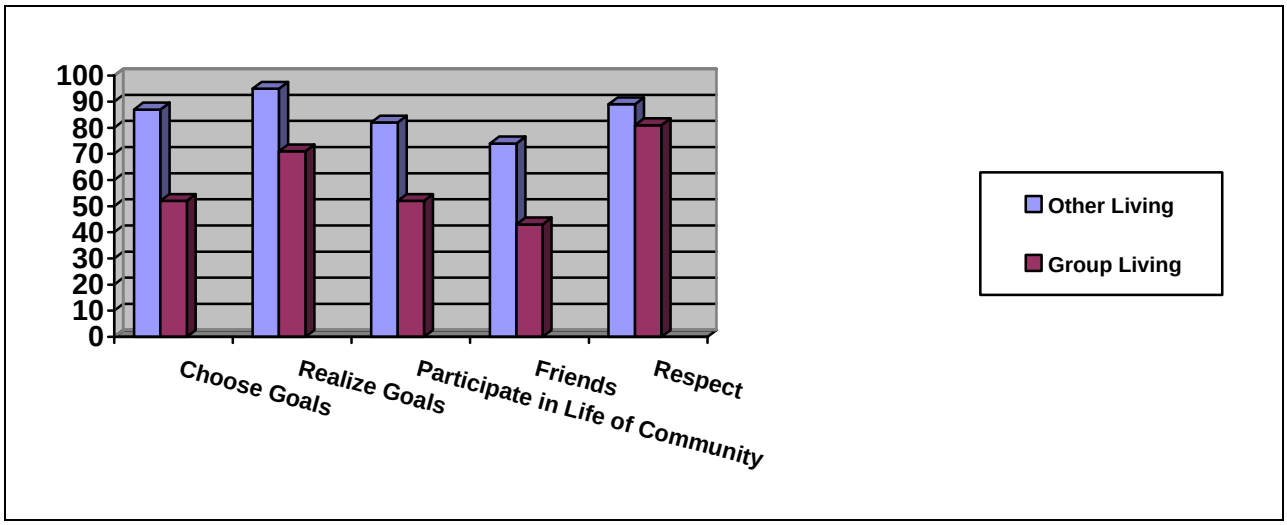
Graph 5.1 Percentage of Outcomes achieved by various age groups – **Factor Three – My Dreams**



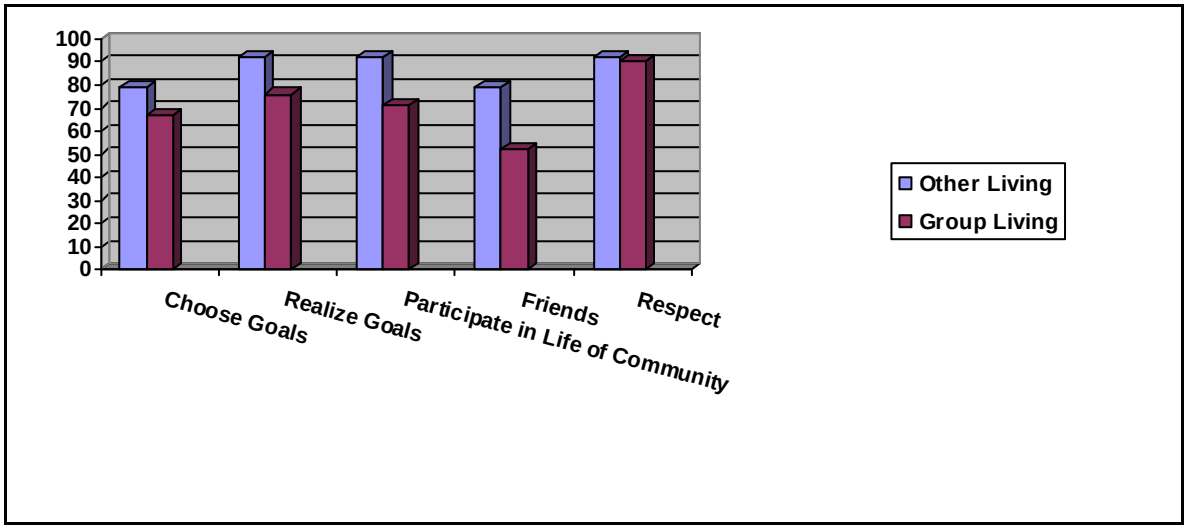
Graph 5.2 Percentage of Supports achieved by various age groups – **Factor Three – My Dreams**



Graph 6.1 Percentage of Outcomes achieved by living arrangement – Factor Three – My Dreams



Graph 6.2 Percentage of Supports achieved by living arrangement – Factor Three – My Dreams



ORGANIZATIONAL ASSURANCES

Assurances of health, safety and welfare emphasize the fundamental importance of maintaining the health, safety, welfare, respect and stability of people receiving supports and services. People and organizations providing supports and services to other people have a basic obligation to guard general health and welfare. Personal Outcomes emphasize the importance of choice, but enabling people to make choices does not relieve staff of the obligations to protect general health and welfare.

The seven organizations accredited between July 1, 2006 and May 31, 2007 using *Personal Outcome Measures® 2000 Edition* obtained the following results:

Table 5 Organizational Assurances of Health, Safety and Welfare

Assurances	Total Number of Organizations	% Present	% Not Present
The organization has employment screening procedures that minimize unnecessary or unreasonable risk.	7	100%	0%
The organization implements procedures in all instances of alleged abuse and neglect.	7	100%	0%
The organization promotes access to primary health care that is coordinated, comprehensive, and continuous.	7	100%	0%
The organization implements emergency procedures.	7	100%	0%
Buildings comply with all applicable fire and sanitation codes.	7	100%	0%
The organization protects the rights of people.	7	100%	0%
The organization uses positive approaches in all service and support activities.	7	100%	0%

STRENGTHS AND COMMENDATIONS

- Assurances for Health, Safety and Human Security remain strong overall for the provider organizations in the South Dakota. During this cycle, there were no providers that received an accreditation with conditions.

RECOMMENDATIONS AND OPPORTUNITIES

- As people achieve higher levels of independence and become more actively involved in their communities, risk factors emerge that organizations traditionally or historically have not had to address. For people and families living with maximum independence or in their own homes, vulnerabilities need to be evaluated and acknowledged. Proactive mechanisms for learning and responding become critical. The organizations need to develop policy and procedure, educate staff, and implement practices that will ensure safeguards for health, safety and welfare and fiscal and legal accountabilities in community life.
  This policy should include at a minimum:
    - Clear expectations of staff to learn about each person's needs in the areas of health care and safe environments
    - How to respond to instances which may be abusive, neglectful or exploitive
    - Clear procedures for response when discoveries of need are made regarding these foundational life areas

A**ssurances of fiscal and legal accountability** stress accountability in resource management. Organizations exercise a public trust and have a responsibility to people receiving services and supports and their families, the community, funders and employees. These assurances remind the organization that financial strength and diligent resource management increases organizational capacity to facilitate outcomes. As resources become scarce, organizations must demonstrate a direct connection between organization process and personal outcomes.

The seven organizations accredited between July 1, 2006 and May 31, 2007 using *Personal Outcome Measures® 2000 Edition* obtained the following results:

Table 6 Organizational Assurances of Fiscal and Legal Accountability

Assurances	Total Number of Organizations	% Present	% Not Present
The organization has a budgeting and accounting system.	7	100%	0%
The organization has an annual independent audit.	7	100%	0%
The organization is accountable for people's money.	7	100%	0%
The organization maintains data and information on costs, personnel, capital budget, and support coordination.	7	100%	0%
The organization's personnel practices meet all governmental fair labor regulations.	7	100%	0%

STRENGTHS AND COMMENDATIONS

- Provider organizations are financially viable as demonstrated by the preparation of annual financial reports and full financial audits and disclosure.

RECOMMENDATIONS TO CONSIDER

- Continue to enhance the measure for costs, personnel, capital budget, and support coordination as related to personal outcome achievement in people's lives.

ORGANIZING PRINCIPLES

The **Organizing Principles** are the basic organizational action strategies that facilitate personal outcomes for people receiving services and supports. They represent a collection of best and most promising practices from organizations that have successfully designed and delivered services based on a personal outcomes approach. As such, the Organizing Principles provide a benchmark for organizations considering a personal outcome orientation to services and supports.

The Organizing Principles bring together action strategies related to leadership, systems development, and quality management and planning. These Organizing Principles communicate messages to staff, families and volunteers, people served and external audiences.

A Decision Matrix is used to determine the level of implementation of each of the Organizing Principles **(Table 7)**. The following is a guideline of the criteria for placing a principle in a particular area of the matrix.

UNDERSTANDING
A Principle is placed in this portion of the matrix when an organization recognizes that a particular Principle is worthy of implementing, but may still be in the planning stages of determining how to implement the Principle. Or perhaps the organization has attempted to implement the Principle, but has changed the means of implementing it.

IMPLEMENTATION
A Principle is considered implemented when it has been put into practice and all elements of the organization responsible for the implementation are aware of how it is to be implemented and maintained. An implemented Principle has not yet begun to garner consistent results from its implementation.

RESULTS
Once a Principle has been fully implemented and everyone understands and is playing his or her role in the implementation of the Principle, there should be evidence of consistent results from having implemented the Principle.

Organizing Principles are group into three categories:

- Leadership
- Systems
- Quality Management and Planning

LEADERSHIP PRINCIPLES

L1. The organization or network defines its primary customer.
L2. People served exercise leadership through choice and self-determination.
L3. The organization or network emphasizes the values of listening, responsiveness, respect, and support for desired outcomes.
L4. The organization or network links service users, families and providers to promote individual relationships and increase system capacity.
L5. The organization or network appoints service users to the board of directors.
L6. The organization or network clearly defines expectations for staff competency and performance.
L7. The organization or network regularly evaluates and provides feedback to its staff on their performance.
L8. The organization or network has a strategy for developing relationships with other agencies/providers in its service area.

FINDINGS

After a noticeable shift of Leadership Principles toward greater implementation and the recognition of results for many of the Principles in 2005-2006, the level of Principles in the results area has increased to 68% in the 2006-2007 review cycle (See **Table 8**). This shift could be the result of new learning and increased expectations at the organizational level.

The following Leadership Principles are found to be strongest for South Dakota organizations reviewed during 2006-2007 (using the threshold of five out of seven to identify strengths):
L1. The organization or network defines its primary customer.
L2. People served exercise leadership through choice and self-determination.
L3. The organization or network emphasizes the values of listening, responsiveness, respect, and support for desired outcomes.
L6. The organization or network clearly defines expectations for staff competency and performance.

L1 remains a strength as identified in last year's report and may represent a statewide trend. The first two in the above list were also areas of strength in the 2005-2006 review cycle and may represent a statewide trend for leadership principles. L3 is new to the list of strengths and may be unique to this sample of organizations.

In 2006-2007, two Leadership Principles show the greatest need for improvement:

L4. The organization or network links service users, families and providers to promote individual relationships and increase system capacity.
L7. The organization or network regularly evaluates and provides feedback to its staff on their performance.

Principles L4 and L7 continue to be areas of need. By contrast, L2, which was in the area of need in 2005-2006, has now emerged as a strength.

STRENGTHS AND COMMENDATIONS

- People served are supported to exercise leadership both within the organizations as part of the Board of Directors and by serving on various committees, as well as within their communities through involvement with People First and other civic organizations.
- The use of the personal interviews has significantly enhanced people's ability to direct decisions that impact their lives.
- Provider organizations have put a great deal of effort into building strong community connections.

RECOMMENDATIONS AND OPPORTUNITIES

- Provider organizations are encouraged to use the foundation of their current community connections to springboard to a new level of strengthening social capitol for all organizational stakeholders including people in services, families, staff members, and administration. Create the vision and image of being a "bridging organization" that can link people and services, and that understands the impact of social ties, reciprocity, and trust-building for all people to experience inclusion in their community.

SYSTEMS PRINCIPLES

S1. The organization or network has a clear statement of its mission.
S2. The organization or network implements a strategy for listening to and learning about each individual.
S3. The organization or network promotes coordinated systems of services that are responsive to the needs and desires of service users.
S4. The organization or network provides service users and other organizations with relevant information.
S5. The organization or network has a strategy for hiring, nurturing, and sustaining staff.
S6. The organization or network provides opportunities for staff training and personal development.
S7. The organization or network has a personnel development strategy for increasing staff and volunteer competence in facilitation, problem solving, and negotiation.
S8. Organizational or network systems promote personal dignity and respect.
S9. Organizational or network systems promote continuity and security.
S10. Organizational or network systems promote natural support relationships.

FINDINGS

For the 2006-2007 review cycle, the trend for Systems Principles is similar to the trend for Leadership Principles. There is a large increase in the number of principles determined to be producing results, from 32% in 2005-2006 to 66% in 2006-2007. (**Table 8**)

In this past year, several Systems Principles have become stronger. The following Systems Principles are found to be strongest for South Dakota organizations reviewed during 2006-2007:

S1. The organization or network has a clear statement of its mission.
S2. The organization or network implements a strategy for listening to and learning about each individual.
S3. The organization or network promotes coordinated systems of services that are responsive to the needs and desires of service users.
S5. The organization or network has a strategy for hiring, nurturing, and sustaining staff.
S6. The organization or network provides opportunities for staff training and personal development.
S8. Organizational or network systems promote personal dignity and respect.

Data from 2006-2007 show that principles S1, S6, and S8 remain strong as was identified during the last review cycle and may represent a trend in South Dakota. S2, S3, and S5 are new to this list and should be considered specific to this organizational sample.

In 2006-2007, three Systems Principles show the greatest need for improvement for these organizations:
S4. The organization or network provides service users and other organizations with relevant information.
S9. Organizational or network systems promote continuity and security.
S10. Organizational or network systems promote natural support relationships.

Principle S10 continues to be an area of need from review year 2005-2006.

STRENGTHS AND COMMENDATIONS

- There is strong commitment among providers to a person-directed philosophy. Additionally, staff is committed to learning about people with whom they work. It is clear that a person-directed values-base has been integrated into systems. Results showed that staff is learning about outcomes in people's lives and areas in which supports are needed. Additionally, this learning is an ongoing relationship building process rather than solely an annual planning event.
- Provider organizations have a strong commitment to continued forward movement of practices and philosophy in order to enhance services for the people they support.

RECOMMENDATIONS AND OPPORTUNITIES

- As people achieve higher levels of independence and become more actively involved in their communities, risk factors emerge that organizations traditionally or historically have not had to address. For people and families living with maximum independence or in their own homes, vulnerabilities need to be evaluated and acknowledged. Proactive mechanisms for learning and responding become critical. The organizations need to develop policy and procedure, educate staff, and implement practices that will ensure safeguards and accountabilities for health, safety and human security in community life.
  This policy should include at a minimum:
    - Clear expectations of staff to learn about each person's needs in the areas of health care and safe environments
    - How to respond to instances which may be abusive, neglectful or exploitive
    - Procedures for response when discoveries of need are made regarding these foundational life areas

QUALITY MANAGEMENT AND PLANNING PRINCIPLES

Q1. The organization or network has a process for eliciting and analyzing feedback on services and supports from service users, employees and providers.
Q2. The organization or network periodically analyzes and documents the relationship between resource allocation and personal outcome attainment.
Q3. The organization or network has a process for collecting and analyzing information.
Q4. Information analysis results in strategies for organizational quality improvement.
Q5. The organization's or network's knowledge management system is based on information about aggregated individual needs and resources within the service area.

FINDINGS

For the 2006-2007 review cycle, there appears to be a shift in Quality Management and Planning Principles showing continued forward movement across the matrix. A greater percentage of these principles (45%) are now in the results area. This is a sharp increase and one that has also been seen with both Leadership and Systems Principles as well.

In 2006-2007, two Quality Management and Planning Principles remain as having the greatest need for improvement:
Q2. The organization or network periodically analyzes and documents the relationship between resource allocation and personal outcome attainment.
Q4. Information analysis results in strategies for organizational quality improvement.

STRENGTHS AND COMMENDATIONS

- Data in this area (**Tables 7 and 8**) suggest that provider organizations are getting stronger in their understanding of these five principles in general.

RECOMMENDATIONS AND OPPORTUNITIES

- Although it appears that provider organizations are getting stronger in the area of Quality Management and Planning, there remains a need to deepen organizational understanding of the intent of these five principles and implement focused strategies which will produce greater and better results organizationally over all across the system.

Overall, more of the 23 organizing principles are now in the results area of the decision matrix (**Table 7**), which would indicate that greater depth of understanding and the implementation of some effective strategies has occurred.

Table 7 Decision Matrix for Organizing Principles 2006-2007

Decision Matrix	Understanding	Implementation	Results
Leadership	L4	L7 L2,L5,L7 L1,L3,L4,L6,L7 L4,L5 L2,L3,L5,L6,L7,L8	L1,L2,L3,L4,L5,L6,L8 L1,L2,L3,L4,L5,L6,L7,L8 L1,L2, L3,L4,L5,L6,L7,L8 L1,L3,L4,L6,L8 L2,L5,L8 L1,L2,L3,L6,L7,L8 L1
Systems	S4	S9,S10 S4,S10 S2,S3,S4,S5,S6,S7,S9 S4,S7,S9,S10 S7 S3,S5,S7,S9	S1,S2,S3,S4,S5,S6,S7S8 S1,S2,S3,S4,S5,S6,S7,S8 S9,S10 S1,S2,S3,S5,S6,S7,S8,S9 S1,S8,S10 S1,S2,S3,S5,S6,S8 S1,S2,S3,S4,S5,S6,S8,S9,S10 S1,S2,S6,S8,S10
Quality Management and Planning	Q2,Q3,Q4,Q5 Q2,Q3,Q4,Q5	Q2 Q1 Q2, Q5 Q2,Q3,Q5 Q2,Q4,Q5 Q1	Q1,Q3,Q4,Q5 Q1,Q3,Q4 Q1,Q4 Q1,Q3 Q1,Q2,Q3,Q4,Q5

Legend: ♦ = Agency 1
♦ = Agency 2
♦ = Agency 3
♦ = Agency 4
♦ = Agency 5
♦ = Agency 6
♦ = Agency 7

Table 8 Decision Matrix for Organizing Principles Three-Year Comparison

Decision Matrix	Understanding	Implementation	Results
Leadership	2004-2005 - 10% 2006-2006 - 22% 2006-2007 - 2%	2004-2005 - 42% 2005-2006 - 28% 2006-2007 - 30%	2004-2005 - 48% 2005-2006 - 48% 2006-2007 - 68%
Systems	2004-2005 - 0% 2005-2006 - 10% 2006-2007 - 2%	2004-2005 - 45% 2005-2006 - 50% 2006-2007 - 32%	2004-2005 - 55% 2005-2006 - 38% 2006-2007 - 66%
Quality Management and Planning	2004-2005 - 43% 2005-2006 - 48% 2006-2007 - 23%	2004-2005 - 37% 2005-2006 - 32% 2006-2007 - 32%	2004-2005 - 20% 2005-2006 - 8% 2006-2007 - 45%

Percentage of Principles found at each level

QUALITY MEASURES 2005® - BASIC ASSURANCES®

In the accreditation review of Black Hills Workshop and Training Center, the *Quality Measures 2005®* were used. There were seven issues identified for indicators in the *Basic Assurances®* section. CQL received a response to the issue identified and validated the information during a follow up visit.

1. **FACTOR ONE, INDICATOR "B", PRACTICE FOR *THE ORGANIZATION SUPPORTS PEOPLE TO EXERCISE THEIR RIGHTS AND RESPONSIBILITIES*.**

   ISSUE(S):

   - Adopt a proactive approach to assessing what rights are important to people. Develop more specific definitions of rights – for example, many list their "favorite right" as choice. Assist the person in more clearly identifying what choices are important to him or her.
   - The practices of supporting people to exercise rights that are important to them are inconsistent. A number of people have guardians and are prevented from exercising those rights that are important to them.
   - Consider requiring the use of the rights assessment for everyone. If the organization chooses to use Personal Outcome data to assess rights, assure that the data collected are valid and reliable.

   RESPONSE/VALIDATION:

   Service Coordinators have been assisted in assessing rights. A sheet listing examples of Choices has been shared with each Service Coordinator and Personal Outcome assessments are being completed for every person receiving services. At one time there were a number of people who listed their "favorite right" as "choice." Now, with further assessment from the Service Coordinators, rights assessments are more specific. A great deal of training for staff and family members has occurred concerning guardianship and lesser forms of assisting people in decision-making. A "Guardianship" brochure has been developed by the organization and has been shared with families, guardians and staff. Staff has received intensive training regarding guardianship and how to work with guardians and parents. Staff and family training included a presentation by an attorney and an advocacy expert.

2. **FACTOR ONE, INDICATOR "D", PRACTICE FOR *THE ORGANIZATION UPHOLDS DUE PROCESS REQUIREMENTS*.**

   ISSUE(S):

   - The Human Rights Committee (HRC) reviews numerous limitations and strongly protects the rights of people in the organization. Consider electing a chairperson of the Human Rights Committee that is not a representative of the organization.
   - Assure that the policies and procedures regarding the Human Rights Committee define the training for committee members.

- Assure that there is always a quorum of the HRC in order to make decisions, that attendance is documented in the HRC minutes, and that people are encouraged to be present when their limitations are discussed.
- Assure that all rights restrictions are presented to the Human Rights Committee. For example, people have money managed by people other than guardians without it being considered as a limitation; diets are implemented without review; personal searches are done without review.
- While the "decision tree" is a helpful way to make decisions about rights, it sometimes leads to a rights limitation being called a support.

RESPONSE/VALIDATION:

- The policies and procedures regarding the Human Rights Committee define the training for committee members, and the policies also spell out what constitutes a quorum of the HRC in order to make decisions. Attendance is documented in the HRC minutes, and people are encouraged through a number of avenues to be present when their limitations are discussed.
- All potential rights restrictions are presented to the Human Rights Committee, even if the team has determined that the action constitutes a support and not a restriction. The HRC is then responsible for defining whether or not the action is a support or restriction. Money management, implementation of diets and personal searches are done only after review.
- Minor changes in the Decision Tree Model and an added sheet of definitions is now a helpful way to make decisions about the difference between rights limitations and supports.

3. **FACTOR ONE, INDICATOR "E", PRACTICE FOR *DECISION-MAKING SUPPORTS ARE PROVIDED TO PEOPLE AS NEEDED.***

ISSUE(S):

- Assure that the system for assessing the need for advocacy, guardianship and alternatives to guardianship is consistently administered.

RESPONSE/VALIDATION:

See comments about guardianship under Factor One, Indicator "B".

4. **FACTOR SIX, INDICATOR "A", SYSTEM AND PRACTICE FOR** *THE ORGANIZATION PROVIDES INDIVIDUALIZED SAFETY SUPPORTS.*

ISSUE(S):

- Revisit the safety assessment to assure that the assessment and the way the questions are asked are individualized (Education, Experience, Exposure). Address such needs as being able to negotiate steps, appropriate number and location of fire exits, knowledge about how and when to use a fire extinguisher, tipping over in a wheelchair, and other safety concerns specific to the person or the particular living environment.
- Assure that the evaluation system is consistently administered. There were indications that once a person answered a safety question appropriately, the question might not be asked again. Assure that all parts of the safety assessment are administered yearly.

RESPONSE/VALIDATION:

- Revised the safety assessment to include question making the assessment more individualized. The assessment is required to be completed annually. Since the assessment changes, all people receiving services are being reassessed using the new form.
- Individualized exit times are being tracked for people receiving services and the information is to be used to determine assessment and training needs.

5. **FACTOR EIGHT, INDICATOR "D", SYSTEM AND PRACTICE FOR** *THE ORGANIZATION TREATS PEOPLE WITH PSYCHOACTIVE MEDICATIONS FOR MENTAL HEALTH NEEDS CONSISTENT WITH NATIONAL STANDARDS OF CARE.*

ISSUE(S):

- Clearly define the separate roles of the Behavior Intervention Committee and the Human Rights Committee.
- Define "restrictive" and "highly restrictive" procedures in the organization policies and procedures.
- The organization could benefit by adding a pharmacist, psychiatrist or other medical professional to the behavior intervention committee.
- Consider adding two components to the behavior support plan review tool: (1) less restrictive options tried prior to the use of more restrictive measures and (2) measure of effectiveness of the intervention plan.
- Assure that there is a plan for emergency approval of psychotropic medications (e.g., phone tree, conference call meeting, etc.).

RESPONSE/VALIDATION:

- The separate roles of the Behavior Intervention Committee and the Human Rights Committee are clearly defined in policy.

- "Restrictive" and "highly restrictive" procedures are defined in the organizational policies and procedures. "Search and seizure" has been added to the list of rights restriction examples in staff training.
- Pharmacists have recently been added to both the behavior intervention committee and the HRC.
- A recent procedure, "Psychotropic Meds: Considerations & Emergency Approvals Prior to Requesting or Administering a Psychotropic Medication"
- A behavior specialist has been retained for a number of people who have very challenging behavior. After observation and staff input, person-specific behavior plans were suggested.
- The organization hosted and audio conference "Drugs and Disabilities – Handle with Care," developed a brochure "Dr., please tell me…," sent staff to training about personality disorders with Dr. Greg Lester, and is planning other training and assistance to staff in dealing with behavioral issues.

6. **FACTOR TEN, INDICATOR "A", PRACTICE FOR *THE ORGANIZATION MONITORS BASIC ASSURANCES®*.**

ISSUE(S):

- Assure that the Personal Outcomes are assessed in a reliable and valid way.
- Enhance the role of stakeholders in the evaluative process. Assure that this is defined in the Basic Assurances® plan.

RESPONSE/VALIDATION:

- The organization has spent a great deal of training time with service coordinators to assure a greater knowledge of how to assess using the Personal Outcome Measures®.
- Service Coordinators have been trained to use decision guidelines in determining the presence or absence of outcomes.
- Various stakeholders are involved in a variety of aspects of the evaluative process.

7. **FACTOR TEN, INDICATOR "B", SYSTEM FOR *A COMPREHENSIVE PLAN DESCRIBES THE METHODS AND PROCEDURES FOR MONITORING BASIC ASSURANCES®*.**

ISSUE(S):

- Prioritize which data streams can effectively evidence the attainment of Basic Assurances®. Track and trend these data streams to find patterns. Identify priority actions to be taken to improve basic assurances. Develop measurable criteria for success. Include a diverse group of stakeholders in this process. Assure that this plan is organization-wide.

RESPONSE/VALIDATION:

- *Basic Assurances*® are monitored continuously using a variety of data streams that are tracked, trended and otherwise analyzed to determine patterns. This analysis is used to evidence the attainment and maintenance of *Basic Assurances*®.

All issues were addressed by the organization and a validation visit took place approximately four months later. Validation demonstrated that these issues were addressed satisfactorily and a 4-year accreditation agreement was offered.

QUALITY MEASURES 2005® - SHARED VALUES

For Black Hills Workshop and Training Center *Quality Measures 2005*® were used. There was only one indicator out of thirty-two identified as requiring action in the measures for *Shared Values*.

The indicator was:

1. FACTOR FOUR, COMMUNITY SETTINGS, INDICATOR "A" FOR *PEOPLE LIVE IN COMMUNITIES*.

ISSUE(S):

- The organization is encouraged to evaluate its operation of large congregate living and day settings.

RESPONSE/VALIDATION:

- The organization has not responded to this issue at this time.

SOCIAL CAPITAL INDEX®

SOCIAL CAPITAL AND CQL'S PERSONAL OUTCOME MEASURES®

Since the introduction of the *Personal Outcome Measures®* in 1993, CQL has asked the question: "What is the relationship between personal outcomes and the supports that make outcomes possible?" After analyzing the personal outcomes database of over 5,500 interviews with people, we are convinced that supports that emphasize social networks and trust are important factors in quality of life for people. Our *Personal Outcome Measures®* database indicates a strong relationship between safety and freedom from abuse and neglect and continued connections to natural support systems and to close, intimate friendships based on trust and reciprocity. People who are connected to natural support networks and who have close intimate relationships are more likely to feel safe and less likely to experience abuse or neglect.

THE ROLE OF ORGANIZATIONS AND SYSTEMS

Social capital redefines the organization's role and purpose. Organizations and systems focus their services and supports on increasing people's social capital. Organizations and systems support people's social capital within the context of the community to facilitate their alliances with others and create access to generic resources. Developing trusting relationships and social ties is also important for families. Assisting families to develop social capital within communities increases their connections to other, more generic resources.

Social capital provides an additional opportunity for leadership. Organizations, by building social capital for all employees, increase the richness of their ties to each other, their families and the community. Organizations evaluate their effectiveness by the impact they have on the social capital of their employees, as well as that of people they support.

Communities are where social capital is earned and spent. Enhancing organizational capabilities through business-to-business ties increases their credibility and reciprocity with key opinion makers and community leaders.

In short, the common unifying task for the organization is to build social capital for the community of interests it serves — people with disabilities, families, volunteers and employees. The concept of social capital simplifies the measurement of quality. After demonstrating that we can deliver the basics in terms of health, safety and security, organizations can measure the social capital of the individual, groups of people, or the whole organization. Social capital as an organizing construct goes beyond normalization, integration or inclusion because it applies to everyone. And we can use the same generic measure for all of us.

MEASURING SOCIAL CAPITAL

We can employ a simple, clear way of measuring social capital using a subset of CQL's 21 *Personal Outcome Measures®*. Our *Personal Outcome Measures®* are a valid, reliable measurement tool. (Gardner and Carran, 2005). Decisions made using this tool are based on interviews conducted by staff reliable in its use and measurement.

CQL's Personal Outcomes interview process forms the basis for our data set. People's narrative and stories lead to decisions about the presence of personal outcomes. From the decisions about certain personal outcomes, we can make inferences about social capital.

Eight of the *Personal Outcome Measures*® are related to social capital:

- People have intimate relationships.
- People live in integrated environments.
- People participate in the life of the community.
- People interact with other members of the community.
- People perform different social roles.
- People have friends.
- People are respected.
- People are connected to natural support networks.

These eight outcomes are about connections we have with others. Measures of intimacy, friendship, natural supports and our community connections are indicators of social capital. Being respected is a sign that you are being treated by others with dignity and your worth is valued. These *Personal Outcome Measures*®, similar to the research data about social capital, are closely tied with health and safety.

THE SOCIAL CAPITAL INDEX®

A factor analysis of the eight *Personal Outcome Measures*® resulted in the identification of two factors. (Cade, Carran and Gardner, 2006) We named the two social capital factors, Bonding and Bridging.

Bonding social capital is what we have with people who are similar to us and who are already part of our social circle. Bridging social capital is the type we have from our relationships with others who are less like us and who exist outside our typical social circle.

Bonding

- People have intimate relationships.
- People participate in the life of the community.
- People have friends.
- People are respected.
- People are connected to natural support networks.

Five personal outcomes make up the Bonding factor. These outcomes are entry points for developing social capital. They are related to our current world and the people and places we already know. They represent the initiation of bonds that make social capital more likely. They are the glue that holds us together.

Bridging

- People live in integrated environments.
- People interact with other members of the community.
- People perform different social roles.

Three personal outcomes make up the bridging factor. They represent the connections we have to the world around us beyond the confines of who we already know, where we already go and what we already do. They represent potential for increased social ties and connections. They are the WD-40 of social interactions.

Put together, these eight personal outcomes represent a broad range of possible entry points to earning social capital. Measuring their collective value enables us to make inferences about the level of social capital for organizations, people and communities. These inferences from the *Social Capital Index*® can facilitate change at the organizational and community level.

USING THE INFORMATION

Organizations and systems use the *Social Capital Index*® in many different ways. As a subset of the *Personal Outcome Measures*®, it is a means for organizations and systems to concretely emphasize and communicate their commitment to social capital. Organizations or systems may also analyze the score alone and determine what needs to change to increase social capital. In this way, the *Social Capital Index*® serves as its own baseline and as an ongoing evaluation of an organization's or systems social capital.

The Social Capital Index® is also used to compare the organization's or system's score to other data sets within the organization/system. These data sets include the cost of services, location of supports, intensity of people's needs and other data incorporated into an integrated quality management system. The relationship between social capital and these other data sets provide a new and different way of viewing the organization's or system's function, purpose and mission.

Organizations and systems also use *Social Capital Index*® data to focus attention on community factors such as education, transportation, employment, health-care and housing that are impacted by the presence or absence of social capital. These factors are not just issues that affect people with disabilities, but all community members.

The *Social Capital Index*®, in conjunction with and correlated to these factors, are powerful tools for supporting community change.

When organizations as a whole have a wealth of social capital, others see them as valued resources. As their value increases, so does their influence. Their leadership and involvement become integral to the success of the entire community. No longer isolated, organizations become a bridge to their communities: the cost of the "toll" paid in the currency of social capital.

Organizations may find it useful to reference national averages as benchmarks when sorting out the various uses of the *Social Capital Index*®. Using our *Personal Outcome Measures*® data we know the following:

- The national average of the eight *Personal Outcome Measures*® in the Social Capital Index® is 60%
- The national average of outcomes present for the Bonding factor is 69%
- The national average of outcomes present for the Bridging factor is 46%

We must be cautious, however, in using any "average" and applying it to organizations. The average is just that — the mix of all the data that results in the score many people would achieve. It does not mean organizations that are average are "good". Use the national averages to get an idea of where your organization, system or group fall in general, and what changes take place over time.

We know social capital is an important currency. Before determining what actions are needed to build social capital networks, organizations need a way to measure where they are now and use that data to facilitate change. CQL's *Social Capital Index*® provides the vehicle for organizations and systems to measure their social capital. Once measured, organizations work to increase it. This ultimately fulfills the mission of organizations to become a bridge to the community.

All people, including people with disabilities and people with mental illness, live better lives with increased social ties. Social capital, as an organizing principle, takes our thinking beyond organizations and programs. It requires organizations, formal and informal, large and small, to be responsible for building networks and connections for all their constituents. And we can best build social capital in communities — not within organizations and programs. Walls and barriers between people with disabilities and people with mental illness, families, volunteers, employees and the community disappear as less formal structures replace the traditional hierarchies, job descriptions and program structures.

DATA PRESENTATION

The following tables depict the Social Capital Index® for a variety for demographic data:

Table 9 Social Capital Index® for all people in the sample

	1993-2006 CQL National (n= 6,424)	2006-2007 South Dakota (n=58)	Differences South Dakota vs. National
Social Capital Index®	60	66	+6
Bonding	64	71	+7
Bridging	53	58	+5

Table 10 Social Capital Index® by Age – South Dakota Sample

	People Over 50 (n= 16)	People Under 50 (n=42)	Differences Under 50 vs. Over 50
Social Capital Index®	61	68	+7
Bonding	69	70	+1
Bridging	48	63	+15

Table 11 Social Capital Index® by Living Arrangement – South Dakota Sample

	People Living in Congregate Settings (n= 20)	People Living in Other Settings (n=38)	Differences Other vs. Congregate Settings
Social Capital Index®	49	72	+23
Bonding	57	75	+18
Bridging	37	67	+30

In the overall aggregate data of 58 people in this year's South Dakota sample, the area of Bridging and Bonding Social Capital are slightly above national averages. Surprisingly, the *Social Capital Index*® for Bridging Social Capital with people in the age range of 50+ falls five percentage points below the overall national average. This is surprising as one might assume that as we age we have greater inclusion in our lives and a greater amount of autonomy in deciding how we will contribute to our communities and connect with people who are outside of our immediate circles, or Bonding Social Capital. However, this is in keeping with the data from Personal Outcomes that shows that people who are age 50+ have lower outcomes present than those who are younger.

Both Bonding and Bridging Social Capital are stronger for the 42 people interviewed who were below age 50 (**Table 10**). Both Bonding and Bridging Social Capital are the lowest for those people who remain living in congregate settings (**Table 11**). Conversely, for the people who live in other settings, such as supported apartments, with family, or who own their own home, the *Social Capital Index*® is the highest. These data, along with data from previous reports, supports continued efforts to move away from congregate settings for people with disabilities as having many positive benefits regarding quality of life.

THE COUNCIL ON QUALITY AND LEADERSHIP
CQL ACCREDITATION

The Council on Quality and Leadership (CQL) provides international leadership in promoting quality of life for people with disabilities and people with mental illness, and the people, organizations and communities who support them. Through our services, publications and public presence, we establish real connections between disabilities' theory and practice, helping those who work in the disability community take the important step from innovative ideas to everyday action.

CQL is an international not-for-profit organization dedicated to excellence in the definition, measurement and improvement of quality of life for people with disabilities and people with mental illness.

Our Vision
A world of dignity, opportunity and community inclusion for all people.

Our Mission
To provide leadership for greater world-wide inclusion and quality of life for people with disabilities.

For over three decades CQL has taken the leadership initiative in developing progressive measures of quality in services and supports, quality of life outcomes and Community Life®.

CQL has over 35 years of experience in defining, measuring and improving the quality of services in organizations and systems through our accreditation process. CQL Accreditation begins with defining quality from the ***person's*** perspective. Since 1993, the *Personal Outcome Measures®* have provided the foundation for CQL's international accreditation program, organizational assessments, and numerous other training and consultation activities throughout North America and in Europe, Asia and Australia.

The CQL national database on Personal Outcomes contains information on over 6,400 individuals who participated in informational meetings during accreditation reviews throughout the United States. Research and analysis of Personal Outcomes and individualized organizational processes, individual demographic information and organizational characteristics is an ongoing priority.

CQL Accreditation is grounded in our core values of person-directed outcomes and provides the skills and tools necessary to measure the direct impact of organizations on the lives of people supported. CQL Accreditation is an objective, external measurement of the quality of services the organization provides.

ATTACHMENT A

Cross-Walk Between the CMS HCBS Quality Framework and CQL's *Quality Measures 2005*®